AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF MISSISSIPPI
COUNTY OF Forrest

Personally appeared before me, the undersigned authority in and for the aforesaid jurisdiction, Roxanne Barnett, who, after being duly sworn, did depose and say:

1. I am the duly authorized custodian of the records attached to this Affidavit;

2. I have first-hand knowledge about the making, maintenance and storage of the attached records;

3. The attached records are a true and correct copy of medical records regarding Albert L. Graham, DOB: [redacted] Social (last 4): [redacted] as kept on file at the office of Hattiesburg Clinic;

4. The attached records were:

   a. Made at or near the time of the occurrence of the matters set forth therein by, or from information transmitted by, a person with knowledge of those matters;
   b. Kept in the course of regularly conducted activity; and
   c. Made as part of the regular practice of the business, institution, association, profession, or occupation.

BY: Hattiesburg Clinic
NAME: Roxanne Barnett
TITLE: Legal Coordinator

SWORN TO AND SUBSCRIBED BEFORE ME this the 2nd day of Oct, 2013.

Bridgette Odom
NOTARY PUBLIC

MY COMMISSION EXPIRES:

JUN 17 2015

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 85813 BRIDGETTE ODOM Commission Expires June 17, 2015 LAMAR COUNTY

EXHIBIT 4

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:12/04/07

Visit Summary

Allergies as of 12/4/2007 — **Never Reviewed**

Not on File

Vitals

(None)

	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
Tobacco Use as of 12/4/2007	Never Assessed			0.0	0.0		

	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
Alcohol Use as of 12/4/2007					

	Drug Use	Source	Types	Frequency	Comments
Drug Use as of 12/4/2007				0.00	

	Sexually Active	Source	Birth Control	Partners	Comments
Sexual Activity as of 12/4/2007					

Medications 12/4/2007

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Kenneth S. Parker, ACNP at 11/26/11 1432

Author:	Kenneth S. Parker, ACNP	Service:	(none)	Author Type:	Acute Care Nurse Practitioner
Filed:	11/26/11 1432	Note Time:	12/04/07 1056		

CLINICAL MESSAGE TYPE: Clinical Message

PRIORITY: Routine
RECEIVER: Marilyn Dixon

MESSAGE:
Marilyn Dixon 12/4/2007 10:58:39 AM

patient was seen in hosp by scott and is coming in for a f/u12/12/07, he is
still having some fluid build up in his chest, need to know if they gave him a
fluid pill to take and needed to be called in for him, please call 601-428-1991

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:12/04/07

NOTES (continued)

Felica Johnson, LPN 12/4/2007 1:26:58 PM

Instructed patient to come to clinic for a nurse visit. Patient voiced understanding.

Felica Johnson, LPN 12/4/2007 3:13:34 PM

Patient came to clinicfor nurse visit.

-- STICKY NOTE (Created by Felica Johnson on 2007/12/04:11:27:16 AM)
(Updated by Felica Johnson on 2007/12/04:11:27:16 AM)
Called Medical Records at SCRMC for Discharge instructions including meds.
-- ACTION TAKEN:
(Signed in IC-Chart by Felica Johnson, LPN on 2007/12/04:03:13:34 PM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:12/04/07

Visit Summary

Allergies as of 12/4/2007 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 12/4/2007	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 12/4/2007					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 12/4/2007				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 12/4/2007					

Medications 12/4/2007

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Kenneth S. Parker, ACNP at 11/26/11 1432

Author:	Kenneth S. Parker, ACNP	Service:	(none)	Author Type:	Acute Care Nurse Practitioner
Filed:	11/26/11 1432	Note Time:	12/04/07 1514		

CLINICAL MESSAGE TYPE: Nurse's Note

PRIORITY: Routine
RECEIVER: Felica Johnson, LPN

Date/Time of Action:

MESSAGE:
Felica Johnson, LPN 12/4/2007 3:34:07 PM

Patient came to clinic c/o shortness of breath. B/P 100/79. Respirations 20.
Pulse 84. Weight 168.5. Lung sounds reveal mild Rales in left base. Upon

NOTES (continued)

listening to heart it semed regular with occasional early systole. Pedal pulses present. No edema noted in l;ower extremities. Encouraged patient to
weigh daily and keep a log and call back with report to let us know if the shortness of breath is better, worse, or the same. Encoraged patient to urinate before weighing first thing in the morning and to call back if shortness of breath became worse. Also no Juglar vein distention noted.

(Signed in IC-Chart by Felica Johnson, LPN on 2007/12/04:03:34:07 PM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:12/07/07

Visit Summary

Allergies as of 12/7/2007 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 12/7/2007	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 12/7/2007					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 12/7/2007				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 12/7/2007					

Medications 12/7/2007

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Kenneth S. Parker, ACNP at 11/26/11 1434

Author:	Kenneth S. Parker, ACNP	Service:	(none)	Author Type:	Acute Care Nurse Practitioner
Filed:	11/26/11 1434	Note Time:	12/07/07 1541		

CLINICAL MESSAGE TYPE: Clinical Message

PRIORITY: Routine
RECEIVER: Marilyn Dixon

MESSAGE:
Marilyn Dixon 12/7/2007 3:41:46 PM

patient need to speak to a nurse asa;, asked to speak to Scott

Scott Parker, ACNP 12/7/2007 4:00:31 PM

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:12/07/07

NOTES (continued)

spoke with wife who stated that pt sob-recc er- she said she would see if pt
would go

(Signed in IC-Chart by Scott Parker, ACNP on 2007/12/07:04:00:31 PM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:12/18/07

Visit Summary

Allergies as of 12/18/2007 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 12/18/2007	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 12/18/2007					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 12/18/2007				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 12/18/2007					

Medications 12/18/2007

NONE

All Orders

Basic metabolic panel — Final result

Ordering User:	Lab In Hlseven Edi 12/18/07 0944	Frequency:	Routine 12/18/07 0944 -
Electronically signed by:	Lab In Hlseven Edi 12/18/07 0944		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Basic metabolic panel — Resulted: 09/24/11 1903, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 12/18/07 0944

Narrative:
-- HISTORICAL INFO:
Location: Mainlab
Orderer Initials: LHAND
Observer Initials: AKS1
LIS Order Number: 7352GL1455
Order Description: BASIC METABOLIC PROF
IC-Chart Test Number: 2684456
(Signed in IC-Chart by Wassium Mouannes, MD on 2007-12-19 15:46:23)

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	137	mEq/L		-	31
Potassium	5.1	mEq/L		-	31
Chloride	98	mEq/L		-	31
CO2	28	mEq/L		-	31
Glucose	99	mg/dl		-	31
BUN	16	mg/dl		-	31
Creatinine	1.17	mg/dl		-	31

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:12/18/07

All Results (continued)

Basic metabolic panel (continued)

Resulted: 09/24/11 1903, Result Status: Final result

Osmolality Calc	275	mOsmL/kg	-	31
Anion Gap	11	mEq/L	-	31
Calcium	9.7	mg/dl	-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:12/18/07

Visit Summary

Allergies as of 12/18/2007 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 12/18/2007	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 12/18/2007					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 12/18/2007				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 12/18/2007					

Medications 12/18/2007

NONE

All Orders

GENERIC LAB — Final result

Ordering User:	Lab In Hlseven Edi 12/18/07 0944	Frequency:	Routine 12/18/07 0944 -
Electronically signed by:	Lab In Hlseven Edi 12/18/07 0944		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

GENERIC LAB — Resulted: 09/24/11 1903, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 12/18/07 0944

Narrative:
-- HISTORICAL INFO:
Location: Mainlab
Orderer Initials: LHAND
Observer Initials: AKS1
LIS Order Number: 7352GL1455
Order Description: GFR ESTIMATION
IC-Chart Test Number: 2684457
(Signed in IC-Chart by Wassium Mouannes, MD on 2007-12-19 15:48:17)

Component	Value	Ref Range	Flag	Comment	Lab
Non-AF American GFR	>60	ml/min		-	31
AF American GFR	>60	ml/min			31

Comment:
********** Test Interpretive Text **********
The National Kidney Disease Education Program presently considers normal kidney function to have an estimated GFR of greater than or equal to 60 ml/min.

All Results (continued)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:12/18/07

Visit Summary

Allergies as of 12/18/2007 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 12/18/2007	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 12/18/2007					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 12/18/2007				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 12/18/2007					

Medications 12/18/2007

NONE

All Orders

Digoxin level — Final result

Ordering User:	Lab In Hlseven Edi 12/18/07 0944	Frequency:	Routine 12/18/07 0944 -
Electronically signed by:	Lab In Hlseven Edi 12/18/07 0944		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Digoxin level — Resulted: 09/24/11 1903, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 12/18/07 0944

Narrative:
-- HISTORICAL INFO:
Location: Mainlab
Orderer Initials: LHAND
Observer Initials: ABJ1
LIS Order Number: 7352GL1455
Order Description: Digoxin
IC-Chart Test Number: 2684505
(Signed in IC-Chart by Wassium Mouannes, MD on 2007-12-19 15:46:21)

Component	Value	Ref Range	Flag	Comment	Lab
Digoxin Lvl	0.7	ng/mL		-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: E1217854
DOB: [redacted], Sex: M
Enc. Date:01/16/08

Flowsheet (all recorded)

Data

Row Name	01/16/08 0000
Vitals	
BP	--
Temp	--
Temp src	--
Pulse	--
Resp	--
SpO2	--
Height	--
Weight	--
Pain 0-10	
Pain Level	--
Location	--
OTHER	
Fall Risk	--
BM	--
Height (Historic)	74 Inches -DI
BSA (Calculated - sq m)	2 sq meters -DI
BMI (Calculated)	21.6 -DI
Diastolic BP Historic	80 -DI
Systolic BP Historic	110 mmHg -DI
Vitals User Historic	Steiner, Diann -DI
Visual Acuity	
R Near	20 -DI
L Near	20 -DI
Bilateral Near	20 -DI
R Distance	20 -DI
L Distance	20 -DI
Bilateral Distance	20 -DI

User Key

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

Initials	Name	Effective Dates
DI	Data Courier Interface	-

All Results

NONE

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: E1217854
DOB: [redacted] Sex: M
Enc. Date:01/16/08

Flowsheet (all recorded)

Data

Row Name	01/16/08 0000
Vitals	
BP	--
Temp	--
Temp src	--
Pulse	--
Resp	--
SpO2	--
Height	--
Weight	--
Pain 0-10	
Pain Level	--
Location	--
OTHER	
Fall Risk	--
BM	--
Height (Historic)	74.5 Inches -DI
BSA (Calculated - sq m)	2 sq meters -DI
BMI (Calculated)	21.3 -DI
Diastolic BP Historic	80 -DI
Systolic BP Historic	110 mmHg -DI
Vitals User Historic	Steiner, Diann -DI
Visual Acuity	
R Near	20 -DI
L Near	20 -DI
Bilateral Near	20 -DI
R Distance	20 -DI
L Distance	20 -DI
Bilateral Distance	20 -DI

User Key

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

Initials	Name	Effective Dates
DI	Data Courier Interface	-

All Results

NONE

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:01/17/08

Visit Summary

Allergies as of 1/17/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 1/17/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 1/17/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 1/17/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 1/17/2008					

Medications 1/17/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Office Visit signed by Wassim E Mouannes, MD at 09/22/11 1320

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	09/22/11 1320	Note Time:	01/17/08 0823		

Cardiology - Laurel Office Visit

DATE OF SERVICE: 01/16/2008
PATIENT NAME: GRAHAM, ALBERT L
MRN: 6948038 DOB: [redacted]

DOB: [redacted]

HISTORY OF PRESENT ILLNESS: This is a pleasant 56-year-old African-American gentleman that I diagnosed with a cardiomyopathy back in December. His ejection fraction was 10 to 15%. He had abnormal nuclear studies suggesting a nonischemic cardiomyopathy. He did have nonsustained ventricular tachycardia, mild renal insufficiency and

NOTES (continued)

congestive heart failure. He returns today for his regular follow-up. He has been almost sober since he saw me last time. He drinks alcohol maybe once a week. He smokes occasionally. He denies any syncope or presyncope. He denies any significant chest pain or shortness of breath.

Past medical history, social history, surgical history, family history, review of systems otherwise unchanged.

CURRENT MEDICATIONS: Reviewed in IC chart.

ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION:

VITAL SIGNS: Pressure 110/80. Pulse 110. Weight 168.

GENERAL: The patient looks alert, oriented and in no distress.

HEENT: PERRLA. Extraocular movements intact.

NECK: No jugular venous distention. No bruits.

CARDIOVASCULAR: Regular tachycardia and displaced PMI.

LUNGS: Clear to auscultation bilaterally. No rales, wheezing.

ABDOMEN: Soft. Nontender. Non-distended.

EXTREMITIES: Good peripheral pulses in all 4 extremities. No clubbing, cyanosis or edema.

NEUROLOGICAL: Intact.

SKIN: Warm and dry.

IMPRESSIONS:
1. Severe cardiomyopathy.
2. Status post congestive heart failure.
3. Mild chronic renal insufficiency.
4. History of non-sustained ventricular tachycardia
5. Sinus tachycardia.

PLAN:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:01/17/08

NOTES (continued)

At this time, I am going to obtain an EKG, increase his Coreg to 6.25 mg b.i.d., and bring him back in 1 week for a revisit.

_____
Wassim E Mouannes MD

TR: WEM/HW D: 01/16/2008 14:07:06 T: 01/17/2008 08:18:00
Conf #: U1401071 Dictation ID: 1941746

cc:

(Signed in IC-Chart by Wassium Mouannes, MD on 2008-01-17 09:22:27)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:01/24/08

Visit Summary

Allergies as of 1/24/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 1/24/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 1/24/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 1/24/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 1/24/2008					

Medications 1/24/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Office Visit signed by Wassim E Mouannes, MD at 09/22/11 1320

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	09/22/11 1320	Note Time:	01/24/08 1426		

Cardiology - Laurel Office Visit

DATE OF SERVICE: 01/24/2008
PATIENT NAME: GRAHAM, ALBERT L
MRN: 6948038 DOB: [redacted]

DOB: [redacted]

HISTORY OF PRESENT ILLNESS: This is a pleasant, 56-year-old, African-American gentleman who is here for 1 week follow-up on his cardiomyopathy which was diagnosed in December. His ejection fraction is 10 to 15%. He did have nonsustained ventricular tachycardia, mild renal insufficiency, and congestive heart failure in the hospital. I

NOTES (continued)

asked him to increase his Coreg, the last time he did not increase it because he thought he could slow his heart beat by himself. His heart rate is still 77 beats per minute denies any chest pain, shortness of breath, palpitations, syncope. He does have mild dyspnea on exertion.

Past medical history, social history, surgical history, family history, review of systems otherwise unchanged.

CURRENT MEDICATIONS: Reviewed IC Chart.

PHYSICAL EXAMINATION:

VITAL SIGNS: Pressure 99/63 Pulse 77.

GENERAL: The patient looks alert, oriented and in no distress.

HEENT: PERRLA. Extraocular movements intact.

NECK: No jugular venous distention. No bruits.

CARDIOVASCULAR: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally. No rales, wheezing.

ABDOMEN: Soft. Nontender. Non-distended.

EXTREMITIES: Good peripheral pulses in all 4 extremities. No clubbing, cyanosis or edema.

NEUROLOGICAL: Intact.

SKIN: Warm and dry.

IMPRESSIONS:
1. Severe nonischemic dilated cardiomyopathy.
2. Mild renal insufficiency.
3. Status post congestive heart failure.
4. Abnormal Adenosine Myoview study back in November showing a large inferolateral defect but no ischemia.

PLAN:
At this time, I have urged the patient to go up on the Coreg to 6.25 twice a day to continue it for 3 months and at that time we may increase it again. He will follow-up with me in 3 months.

NOTES (continued)

Wassim E Mouannes MD

TR: WEM/HW D: 01/24/2008 09:56:42 T: 01/24/2008 14:21:33
Conf #: U1418439 Dictation ID: 1964495

cc:

(Signed in IC-Chart by Wassium Mouannes, MD on 2008-01-24 15:39:18)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:02/11/08

Visit Summary

Allergies as of 2/11/2008 — **Never Reviewed**

Not on File

Vitals

(None)

	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
Tobacco Use as of 2/11/2008	Never Assessed			0.0	0.0		

	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
Alcohol Use as of 2/11/2008					

	Drug Use	Source	Types	Frequency	Comments
Drug Use as of 2/11/2008				0.00	

	Sexually Active	Source	Birth Control	Partners	Comments
Sexual Activity as of 2/11/2008					

Medications 2/11/2008

NONE

All Orders

Protime-INR — Final result

Ordering User:	Lab In Hlseven Edi 02/11/08 0000	Frequency:	Routine 02/11/08 -
Electronically signed by:	Lab In Hlseven Edi 02/11/08 0000		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Protime-INR — Resulted: 09/24/11 1923, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 02/11/08 0000

Narrative:
-- HISTORICAL INFO:
Location: HEARTCARE
Heart Care Center: Heart Care Center, 404 South 13th Avenue
Laurel, MS 39441
Orderer Initials: Logan Hand
LIS Order Number: 1544323
Order Description: Prothrombin Time
IC-Chart Test Number: 2793900
(Signed in IC-Chart by Scott Parker, ACNP on 2008-02-11 12:50:09)

Component	Value	Ref Range	Flag	Comment	Lab
Prothrombin Time	20.1	Seconds		-	31
INR	1.7			-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB [redacted] Sex: M
Enc. Date:02/11/08

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:02/11/08

Visit Summary

Allergies as of 2/11/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/11/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/11/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/11/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/11/2008					

Medications 2/11/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Kenneth S. Parker, ACNP at 11/26/11 1455

Author:	Kenneth S. Parker, ACNP	Service:	(none)	Author Type:	Acute Care Nurse Practitioner
Filed:	11/26/11 1455	Note Time:	02/11/08 0836		

CLINICAL MESSAGE TYPE: Anticoag Visit Note

PRIORITY: Routine
RECEIVER: Kenneth Johnson, RN

Diagnosis: Cardiomyopathy
INR Range: 2.0 and amp;#45; 3.0
Dose: 7.5mg q day
Next Visit: 2/14/2007
Patient Response: Patient verbalized understanding
INR Test Result: 1.7

MESSAGE:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/11/08

NOTES (continued)

Kenneth Johnson, RN 2/11/2008 8:42:06 AM

new Coumadin patient- need to verify Diagnosis. He has two Lovenox 80mg sq
bid inj for today.

(Signed in IC-Chart by Kenneth Johnson, RN on 2008/02/11:08:42:06 AM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:02/14/08

Visit Summary

Allergies as of 2/14/2008 — **Never Reviewed**

Not on File

Vitals

(None)

	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
Tobacco Use as of 2/14/2008	Never Assessed			0.0	0.0		

	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
Alcohol Use as of 2/14/2008					

	Drug Use	Source	Types	Frequency	Comments
Drug Use as of 2/14/2008				0.00	

	Sexually Active	Source	Birth Control	Partners	Comments
Sexual Activity as of 2/14/2008					

Medications 2/14/2008

NONE

All Orders

Protime-INR — Final result

Ordering User:	Lab In Hlseven Edi 02/14/08 0000	Frequency:	Routine 02/14/08 -
Electronically signed by:	Lab In Hlseven Edi 02/14/08 0000		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Protime-INR — Resulted: 09/24/11 1925, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 02/14/08 0000

Narrative:
-- HISTORICAL INFO:
Location: HEARTCARE
Heart Care Center: Heart Care Center, 404 South 13th Avenue
Laurel, MS 39441
Orderer Initials: Logan Hand
LIS Order Number: 1550509
Order Description: Prothrombin Time
IC-Chart Test Number: 2804270
(Signed in IC-Chart by Wassium Mouannes, MD on 2008-02-14 14:26:52)

Component	Value	Ref Range	Flag	Comment	Lab
Prothrombin Time	19.9	Seconds		-	31
INR	1.7			-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/14/08

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/14/08

Visit Summary

Allergies as of 2/14/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/14/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/14/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/14/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/14/2008					

Medications 2/14/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Wassim E Mouannes, MD at 11/26/11 1457

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	11/26/11 1457	Note Time:	02/14/08 0821		

CLINICAL MESSAGE TYPE: Anticoag Visit Note

PRIORITY: Routine
RECEIVER: Kenneth Johnson, RN

Diagnosis: Cardiomyopathy
INR Range: 2.5 and amp;#45; 3.5
Dose: 10mg q day
Next Visit: 2/ 18/2008
Patient Response: Patient verbalized understanding
INR Test Result: 1.7

MESSAGE:

NOTES (continued)

(Signed in IC-Chart by Kenneth Johnson, RN on 2008/02/14:08:22:40 AM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/18/08

Visit Summary

Allergies as of 2/18/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/18/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/18/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/18/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/18/2008					

Medications 2/18/2008

NONE

All Orders

Protime-INR — Final result

Ordering User:	Lab In Hlseven Edi 02/18/08 0000	Frequency:	Routine 02/18/08 -
Electronically signed by:	Lab In Hlseven Edi 02/18/08 0000		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Protime-INR — Resulted: 09/24/11 1927, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 02/18/08 0000

Narrative:
-- HISTORICAL INFO:
Location: HEARTCARE
Heart Care Center: Heart Care Center, 404 South 13th Avenue
Laurel, MS 39441
Orderer Initials: Logan Hand
LIS Order Number: 1555332
Order Description: Prothrombin Time
IC-Chart Test Number: 2812419
(Signed in IC-Chart by Wassium Mouannes, MD on 2008-02-18 14:15:02)

Component	Value	Ref Range	Flag	Comment	Lab
Prothrombin Time	30.2	Seconds		-	31
INR	2.5			-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/18/08

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/19/08

Visit Summary

Allergies as of 2/19/2008 — **Never Reviewed**

Not on File

Vitals

(None)

	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
Tobacco Use as of 2/19/2008	Never Assessed			0.0	0.0		

	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
Alcohol Use as of 2/19/2008					

	Drug Use	Source	Types	Frequency	Comments
Drug Use as of 2/19/2008				0.00	

	Sexually Active	Source	Birth Control	Partners	Comments
Sexual Activity as of 2/19/2008					

Medications 2/19/2008

NONE

All Orders

Protime-INR — Final result

Ordering User:	Lab In Hlseven Edi 02/19/08 0000	Frequency:	Routine 02/19/08 -
Electronically signed by:	Lab In Hlseven Edi 02/19/08 0000		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Protime-INR — Resulted: 09/24/11 1927, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 02/19/08 0000

Narrative:
-- HISTORICAL INFO:
Location: HEARTCARE
Heart Care Center: Heart Care Center, 404 South 13th Avenue
Laurel, MS 39441
Orderer Initials: Logan Hand
LIS Order Number: 1557277
Order Description: Prothrombin Time
IC-Chart Test Number: 2815720
(Signed in IC-Chart by Wassium Mouannes, MD on 2008-02-19 09:55:34)

Component	Value	Ref Range	Flag	Comment	Lab
Prothrombin Time	37.0	Seconds		-	31
INR	3.1			-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/19/08

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: E1217854
DOB: [redacted], Sex: M
Enc. Date:02/19/08

Visit Summary

Allergies as of 2/19/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/19/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/19/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/19/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/19/2008					

Medications 2/19/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Historical Provider, MD at 11/26/11 1459

Author:	Historical Provider, MD	Service:	(none)	Author Type:	Physician
Filed:	11/26/11 1459	Note Time:	02/19/08 0934		

CLINICAL MESSAGE TYPE: Anticoag Visit Note

PRIORITY: Routine
RECEIVER: Kenneth Johnson, RN

Diagnosis: Cardiomyopathy
INR Range: 2.0 and amp;#45; 3.0
Dose: 7.5mg alt with 10mg qod
Next Visit: 2/22/2008
Patient Response: Patient verbalized understanding
INR Test Result: 3.1

MESSAGE:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: E1217854
DOB: [redacted], Sex: M
Enc. Date:02/19/08

NOTES (continued)

(Signed in IC-Chart by Kenneth Johnson, RN on 2008/02/19:09:35:24 AM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:02/21/08

Visit Summary

Allergies as of 2/21/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/21/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/21/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/21/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/21/2008					

Medications 2/21/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Wassim E Mouannes, MD at 11/26/11 1500

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	11/26/11 1500	Note Time:	02/21/08 1150		

CLINICAL MESSAGE TYPE: Clinical Message

PRIORITY: Routine
RECEIVER: Marilyn Dixon

MESSAGE:
Marilyn Dixon 2/21/2008 11:51:20 AM

patient need a letter written to be given to the Office Of disabilty, saying
that he is disabled, please call jenetta, [redacted], or patient home
[redacted]

NOTES (continued)

Wassium Mouannes, MD 3/3/2008 2:24:08 PM

give him copy of the Progress note, if they still need another letter, let me
know

Debra Farve, Medical Assistant 3/3/2008 4:59:27 PM

PROGRESS NOTES ARE PRINTED OFF AND IN BOX IN FRONT OFFICE FOR HIM TO PICK UP.
L/M AT PTS HOME NUMBER.

(Signed in IC-Chart by Debra Farve, Medical Assistant on 2008/03/03:04:59:27
PM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:02/22/08

Visit Summary

Allergies as of 2/22/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/22/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/22/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/22/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/22/2008					

Medications 2/22/2008

NONE

All Orders

Protime-INR — Final result

Ordering User:	Lab In Hlseven Edi 02/22/08 0000	Frequency:	Routine 02/22/08 -
Electronically signed by:	Lab In Hlseven Edi 02/22/08 0000		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Protime-INR — Resulted: 09/24/11 1929, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 02/22/08 0000

Narrative:
-- HISTORICAL INFO:
Location: HEARTCARE
Heart Care Center: Heart Care Center, 404 South 13th Avenue
Laurel, MS 39441
Orderer Initials: Tracey McGrew
LIS Order Number: 1563233
Order Description: Prothrombin Time
IC-Chart Test Number: 2825872
(Signed in IC-Chart by Wassium Mouannes, MD on 2008-02-22 12:53:40)

Component	Value	Ref Range	Flag	Comment	Lab
Prothrombin Time	38.6	Seconds		-	31
INR	3.2			-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:02/22/08

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/22/08

Visit Summary

Allergies as of 2/22/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 2/22/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 2/22/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 2/22/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 2/22/2008					

Medications 2/22/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Wassim E Mouannes, MD at 11/26/11 1500

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	11/26/11 1500	Note Time:	02/22/08 1038		

CLINICAL MESSAGE TYPE: Anticoag Visit Note

PRIORITY: Routine
RECEIVER: Patsy Baker, RN

Diagnosis: Cardiomyopathy
INR Range: 2.0 and amp;#45; 3.0
Dose: 7.5 mg alt with 10 mg qod
Next Visit: 1 week
Patient Response: Patient verbalized understanding
INR Test Result: 3.2

MESSAGE:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:02/22/08

NOTES (continued)

Patsy Baker, RN 2/22/2008 10:40:17 AM

cont. as above

(Signed in IC-Chart by Patsy Baker, RN on 2008/02/22:10:40:17 AM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:03/10/08

Visit Summary

Allergies as of 3/10/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 3/10/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 3/10/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 3/10/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 3/10/2008					

Medications 3/10/2008

NONE

All Orders

Protime-INR — Final result

Ordering User:	Lab In Hlseven Edi 03/10/08 0000	Frequency:	Routine 03/10/08 -
Electronically signed by:	Lab In Hlseven Edi 03/10/08 0000		
Class:	Normal	Quantity:	1
Lab status:	Final result		

All Results

Protime-INR — Resulted: 09/24/11 1937, Result Status: Final result

Resulting Lab: UNKNOWN HISTORICAL LAB
Specimen: 03/10/08 0000

Narrative:
-- HISTORICAL INFO:
Location: HEARTCARE
Heart Care Center: Heart Care Center, 404 South 13th Avenue
Laurel, MS 39441
Orderer Initials: Logan Hand
LIS Order Number: 1585657
Order Description: Prothrombin Time
IC-Chart Test Number: 2863727
(Signed in IC-Chart by Wassium Mouannes, MD on 2008-03-10 16:51:57)

Component	Value	Ref Range	Flag	Comment	Lab
Prothrombin Time	18.6	Seconds		-	31
INR	1.6			-	31

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:03/10/08

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
31 - Unknown	UNKNOWN HISTORICAL LAB	Unknown	Unknown	09/19/11 1414 - Present
	UNKNOWN HISTORICAL LAB	Unknown	Unknown	Create - Present

NOTES

No notes of this type exist for this admission.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:03/10/08

Visit Summary

Allergies as of 3/10/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 3/10/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 3/10/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 3/10/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 3/10/2008					

Medications 3/10/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Wassim E Mouannes, MD at 11/26/11 1506

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	11/26/11 1506	Note Time:	03/10/08 1049		

CLINICAL MESSAGE TYPE: Anticoag Visit Note

PRIORITY: Routine
RECEIVER: Patsy Baker, RN

Diagnosis: Cardiomyopathy
INR Range: 2.0 and amp;#45; 3.0
Dose: 7.5 mg alt 10 mg qod
Next Visit: 1 week
Patient Response: Patient verbalized understanding
INR Test Result: 1.6

MESSAGE:

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:03/10/08

NOTES (continued)

Patsy Baker, RN 3/10/2008 10:52:21 AM

Pt. doesn't know why level dorpped, didn't miss any doses. Says he usually
has a beer every day but didn't this week. Will decrease dose to 7.5 mg TT,
10 mg all other days.

(Signed in IC-Chart by Patsy Baker, RN on 2008/03/10:10:52:21 AM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted], Sex: M
Enc. Date:03/21/08

Visit Summary

Allergies as of 3/21/2008 — **Never Reviewed**

Not on File

Vitals

(None)

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Quit Date
as of 3/21/2008	Never Assessed			0.0	0.0		

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 3/21/2008					

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 3/21/2008				0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 3/21/2008					

Medications 3/21/2008

NONE

Orders

All Orders

NONE

All Results

NONE

NOTES

Note signed by Wassim E Mouannes, MD at 11/26/11 1510

Author:	Wassim E Mouannes, MD	Service:	(none)	Author Type:	Physician
Filed:	11/26/11 1510	Note Time:	03/21/08 0826		

CLINICAL MESSAGE TYPE: Clinical Message

PRIORITY: Routine
RECEIVER: Marilyn Dixon

MESSAGE:
Marilyn Dixon 3/21/2008 8:27:04 AM

patient need meds called in to walmart Laurel lasix

Debra Farve, Medical Assistant 3/21/2008 12:37:49 PM

NOTES (continued)

faxed to walmart in laurel.

(Signed in IC-Chart by Debra Farve, Medical Assistant on 2008/03/21:12:37:49
PM)

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

LETTERS

Letter on: 4/2/08 by: 5780 Status:

.

April 2, 2008

Albert L Graham
[redacted]

RE: Patient ID # 6948038

Dear Albert Graham

This letter is being sent to you because you missed your appointment with

Wassim E Mouannes on March 19, 2008.

If you have not already done so, please call our office at (601) 425-5544 at
your earliest convenience to reschedule.

Sincerely

HATTIESBURG CLINIC

GRAHAM,ALBERT L
MRN: 6948038
DOB: [redacted] Sex: M
Enc. Date:04/02/08

Wassim E Mouannes

1430 Jefferson Street
Laurel,MS 39440

/adm

END OF REPORT

MAR 04 2010

Faxed

Fax 423-5325

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that I may refuse to sign this authorization. I understand that when this information is used or disclosed, it may be subject to being redisclosed and may no longer be protected by federal privacy regulations.

Patient Name: Albert Graham Medical Record Number: [redacted]
Social Security Number: [redacted] Date of Birth: [redacted]

Individual/Organization authorized to make the disclosure: Hattiesburg Clinic

Date(s) of service to be disclosed:

Please check the type of information to be used or disclosed:

___ Admission Record	___ History & Physical	___ Immunization Chart
___ Emergency Record	___ Operative Report	___ Physician Clinic Visits
___ Discharge Summary	___ Laboratory Reports	___ Films, slides, or videos
___ Radiology Reports	___ Entire Record	___ Other

X General Abstract (Includes: Admission record, D/C summary, H&P, ER record, consults, lab, radiology, EKG, EEG, operative report, cardio respiratory reports, other dictated reports)

This information may be disclosed to and used by the following individual or organization:

Jones County Jail
(Name and Address)

for the purpose of Continued Care

- I understand that these records may include information relating to AIDS (Acquired Immunodeficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, or treatment of alcohol and/or drug abuse.
- I understand that I have a right to revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have an effect on any actions taken in reliance on my authorization before the disclosing organization received the revocation. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- To request a Revocation of Authorization form, I may contact: SCRMC Privacy Officer, P.O. Box 607, Laurel, MS 39441.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
(If no date is specified, this authorization will expire in six months from the date it is signed.)
☐ This authorization will not expire because my protected health information is being disclosed for research purposes.
- I understand that treatment, payment, enrollment, or eligibility for benefits may be conditioned on obtaining the authorization in the following circumstances:
  - For research related purposes
  - If the authorization is sought by the health plan for eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations.
  - When the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

NOTICE TO PATIENT: The patient or patient's representative may inspect and/or request a copy of the health information to be used or disclosed in accordance with SCRMC policies.

Patient Name: Albert Graham
(Please Print)

Signature of patient or patient's representative: Albert Graham Date: 2-17-10

If signed by legal representative, relationship to patient:

Witness:

TO BE COMPLETED BY PROVIDER:

Complete only if authorization is for marketing purposes.
SCRMC ☐ will ☐ will not receive direct or indirect remuneration or compensation in exchange for using or disclosing the information listed above.

Date of Disclosure: Clerk Initials:

DO NOT WRITE BELOW THIS LINE
SOUTH CENTRAL REGIONAL MEDICAL CENTER

PATIENT BARCODE

DO NOT WRITE BELOW THIS LINE

6948038
RELEASE OF INFORMATION
DATE: 3-4-10 PAGES: 2
MAILED/FAXED EMP. 60

AUTHORIZATION TO DISCLOSE INFORMATION

JONES COUNTY SHERIFF'S DEPARTMENT
JONES COUNTY ADULT DETENTION FACILITY
SHERIFF ALEX HODGE

FACSIMILE TRANSMITTAL SHEET

TO: The Heart Center FROM: Counsel

DATE: 3-2-10 TOTAL NO. OF PAGES INCLUDING COVER: 2

FAX NUMBER: 601-425-5525 RE:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

601-649-7502
5178 HIGHWAY 11 NORTH
ELLISVILLE, MS 39437

HATTIESBURG CLINIC

COUMADIN CONSENT

NAME: Albert Graham DATE OF BIRTH: [redacted]

HISTORY#: 6948038 PHYSICIAN: mouame J

AGE: 54 SEX: F (M) (Circle)

Because of a particular medical diagnosis my Physician/Nurse Practitioner has placed me on Coumadin/warfarin therapy to decrease the possibility of blood clots forming within my body.

I have received a copy of the "*Medication Guide for Coumadin*" from Bristol Myers Squibb.

I have read it and the information has been reviewed with me.

I have had a chance to ask my physician or nurse questions about Coumadin/warfarin, which were answered to my satisfaction.

I understand the risks and benefits of the therapy which include the following:

- **Coumadin can cause serious and even life threatening bleeding.**
- **It is imperative to see the "Coumadin Clinic" nurse on a regular basis.**
- **Sometimes more frequent blood work will be necessary to keep my blood clotting in the proper range.**
- **Even with the blood work being in the proper range bleeding can still occur.**
- **I must report immediately any signs or symptoms of bleeding to my doctor or go to the nearest emergency room.**

I understand that the direct supervision of my Coumadin therapy will be monitored by registered nurses under the supervision of an Internal Medicine physician.

A Graham
Print Name

Self
Self or relationship to patient

Albert A Graham 2-14-08
Signature of patient or person authorized

2-14-08
Date

RN
Witness (signature)

2-14-08
Date

1335 (2/07)

3PGS

6948

ECHOCARDIOGRAPHIC REPORT

GRAHAM, ALBERT
7837569
Wassim Mouannes, MD

DATE OF STUDY 02/06/08
DATE OF BIRTH [redacted]
ORDERING PHYSICIAN Dr. Mouannes

INDICATION FOR STUDY. Stroke.

RESULTS. This is a good quality echocardiographic study. The patient appears to be in sinus rhythm. Left ventricular cavity size was mildly enlarged with normal wall thickness. Left ventricular systolic function was severely reduced with an ejection fraction of 20%, with severe global hypokinesis. The right atrium, right ventricle were normal. The aortic valve, mitral valve, tricuspid valve, pulmonic valve were normal. There appears to be a mobile filament on the septal wall of the left ventricle, which possibly could represent a chorda tendineae, but also can be representing a thrombus. Color Doppler flow reveals moderate mitral regurgitation, mild tricuspid regurgitation. Aortic root was normal. No pericardial effusion seen. Diastolic function was not assessed.

CONCLUSION. Severe left ventricular dysfunction, mild tricuspid regurgitation, moderate mitral regurgitation, possible thrombotic ligament on the septal wall versus chorda tendineae. Transesophageal echocardiogram is recommended for further evaluation.

Wassim Mouannes, MD

D: 02/06/08
T: 02/06/08/dn

cc: Cardiorespiratory Department
files

ECHOCARDIOGRAPHIC REPORT

GRAHAM, ALBERT
7837569
Wassim Mouannes, MD
162

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SOUTH CENTRAL

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GRAHAM, ALBERT
7837569
Wassim Mouannes, M.D.

TRANSESOPHAGEAL ECHOCARDIOGRAM

DATE OF SERVICE: 02/07/08

DATE OF BIRTH: [redacted]

PRIMARY CARE PHYSICIAN: None

INDICATION: Stroke

PROCEDURE: After the patient gave us his informed consent, he was brought to the cath lab holding area in fasting state. The posterior pharynx was anesthetized using local Citacaine. After adequate sedation was obtained using Versed and Fentanyl, the transesophageal probe was intubated into the esophagus without difficulties. Mid-esophageal views were obtained.

FINDINGS:

AORTIC VALVE: The aortic valve appears to be a tri-leaflet valve without any vegetation, stenosis, or regurgitation.

LEFT VENTRICLE: The left ventricle appears to be mildly thickened, moderately enlarged. There appears to be severe left ventricular systolic dysfunction. The apex was not well visualized. There was no obvious evidence of thrombus or masses in the left ventricle.

MITRAL VALVE: The mitral valve appears to be a bi-leaflet valve with good opening. There appears to be moderate to severe central jet of mitral regurgitation present.

The left atrium and left atrial appendage were well visualized and appears to be clear of any clots.

INTRA-ATRIAL SEPTUM: The intra-atrial septum was well visualized. Color Doppler flow and saline bubble injection reveals no evidence of shunt of PFO.

The right atrium and right ventricle appear to be free of disease.

TRICUSPID VALVE AND PULMONIC VALVE: There appears to be mild to moderate tricuspid regurgitation. The pulmonic valve was not well visualized.

TRANSESOPHAGEAL ECHOCARDIOGRAM
GRAHAM, ALBERT
7837569
Wassim Mouannes, M.D. 162

SOUTH CENTRAL

TRANSESOPHAGEAL ECHOCARDIOGRAM

GRAHAM, ALBERT
7837569
Wassim Mouannes, M.D.

CONTINUED, PAGE 2

PERICARDIUM: No pericardial effusion seen.

AORTA: The descending aorta, aortic arch, descending aorta were well visualized and appeared to be free of atherosclerosis.

CONCLUSION: Negative transesophageal echocardiogram study for any evidence of cardiac source of emboli. There is evidence of severe left ventricular systolic dysfunction, moderate to severe mitral regurgitation.

Wassim Mouannes, M.D.

dd: 02/07/08 (08:05)
dt: 02/07/08/ne

TRANSESOPHAGEAL ECHOCARDIOGRAM

ADDENDUM

GRAHAM, ALBERT
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Wassim Mouannes, M.D.

SOUTH CENTRAL

H# 69480
4 page

HISTORY
PHYSICAL EXAMINATION

GRAHAM, ALBERT L.
7837569
Wassim Mouannes, MD

DATE OF BIRTH [redacted]
ADMITTED 02/05/08

CHIEF COMPLAINT. Acute left parietal cerebrovascular accident.

HISTORY OF PRESENT ILLNESS. This is a 56-year-old black male, known to the Heart Care Center with a past medical history of nonischemic cardiomyopathy with an ejection fraction of 10% to 15%, nonsustained ventricular tachycardia, mild renal insufficiency, congestive heart failure. The patient was walking today, and while he was walking, he states that his right arm began to "flap," and that he was unable to control his right arm. He states that he also felt tingling and numbness in his right upper extremity, and in his right leg. The patient states that he was able to walk and slowly was able to walk back home. The patient states that over the course of the day, his symptoms have gradually improved, and now he no longer has right upper extremity weakness. He is able to move his right arm and right leg. The patient states also that when he first noticed the symptoms, approximately 9:30 a.m. this morning, he was having a hard time articulating his words at that time, but since then, he notices improvement. The patient denies any chest pain, shortness of breath, palpitations, syncope, or presyncope.

PAST HISTORY. Past Medical History: See above. Past Surgical History: Appendectomy.

HOME MEDICATIONS
1. Aspirin 81 mg once daily.
2. Coreg 6.25 mg 1 twice a day.
3. Digitek 0.125 mg once a day.
4. Diovan 40 mg once a day.
5. KCl 20 mEq once a day.
6. Lasix 40 mg twice a day.

ALLERGIES. No known drug allergies.

FAMILY HISTORY. His sister has congestive heart failure and chronic obstructive pulmonary disease. His mother is living and is healthy. Father's history is unknown.

SOCIAL HISTORY. He is married. He smokes about a pack per day. The patient used to drink about 6 beers per day. He denies any heavy liquor. Continued

HISTORY
PHYSICAL EXAMINATION

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HISTORY
PHYSICAL EXAMINATION

GRAHAM, ALBERT L.
7837569
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Continuation, page 2 of History

REVIEW OF SYSTEMS.
General: Denies recent change in appetite or weight. Denies fever or chills.
HEENT: Denies recent change in vision or hearing. Denies tinnitus. Denies blurred vision, eye pain, ear pain, or dysphagia.
Cardiac: See history of present illness. In addition, denies palpitations, orthopnea, or paroxysmal nocturnal dyspnea.
Respiratory: Denies a history of asthma, emphysema, or exposure to tuberculosis. Denies cough, hemoptysis, night sweats, or dyspnea on exertion.
GI: Denies nausea, vomiting, diarrhea, constipation, abdominal pain, melena, or hematochezia. Denies history of gastroesophageal reflux disease.
GU: Denies hematuria, dysuria, frequency, or hesitancy.
Integumentary: Denies pruritus, rash, or lesion.
Musculoskeletal: Denies muscle weakness, back pain, or change in range of motion.
Endocrine: Denies heat or cold intolerance.
Hematologic: Denies history of anemia, blood clots, or clotting disorder.
Psychiatric: Denies problems with anxiety or depression.
Neurological: Denies history of syncope, seizures or stroke. Denies problems with headache.

Brandi Garris, MSN, ACNP

Wassim Mouannes, MD

D: 02/05/08
T: 02/05/08/dg

HISTORY
PHYSICAL EXAMINATION

GRAHAM, ALBERT L.
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HISTORY
PHYSICAL EXAMINATION

GRAHAM, ALBERT L.
7837569
Wassim Mouannes, MD

ADMITTED 02/05/08

GENERAL. The patient is alert and oriented, in no acute distress.

HEENT. Pupils are round, regular, equal, and reactive to light and accommodation.

NECK. No jugular venous distention or carotid bruits.

CHEST. Lungs are clear without rhonchi, rales, or wheeze.

HEART. Regular rate and rhythm without any obvious murmur, rub, or gallop.

ABDOMEN. Soft, nontender, with positive bowel sounds.

EXTREMITIES. No clubbing, cyanosis, or edema. Pedal pulses are 2+ in the upper and lower extremities.

SKIN. Warm, dry, and intact.

NEUROLOGIC. The patient is alert and oriented x3.

DATA. EKG showed sinus rhythm with leftward axis deviation, poor R-wave progression with some nonspecific ST- and T-wave abnormalities. CBC reveals white blood cell count of 4.4, hemoglobin 13.2, hematocrit 38.9, platelets 253, sodium 141, potassium 3.8, chloride 105, CO2 of 27, calcium 9.0, glucose 112. BUN 12, creatinine 1.28, pro-time 13.1, INR 1.1, APTT 27.2. Digoxin level is less than 0.2.

ADMITTING IMPRESSION
1. Acute left parietal stroke.
2. History of severe, nonischemic cardiomyopathy with an ejection fraction of 15%.
3. Mild renal insufficiency.
4. History of nonsustained ventricular tachycardia.

Continued

HISTORY
PHYSICAL EXAMINATION
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HISTORY
PHYSICAL EXAMINATION

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Wassim Mouannes, MD

Continuation, page 2 of Physical Examination

PLAN

1. Will admit to telemetry.
2. Neurologic consultation.
3. Lovenox 40 mg subcutaneous daily.
4. The patient may need to begin Coumadin secondary to severely reduced ejection fraction, which may have possibly been the cause of the patient's stroke.
5. Further recommendations pending the patient's clinical course and response to treatment.

Brandi Garris, MSN, ACNP

Wassim Mouannes, MD

D: 02/05/08
T: 02/05/08/dn

HISTORY
PHYSICAL EXAMINATION

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SOUTH CENTRAL REGIONAL MEDICAL CENTER

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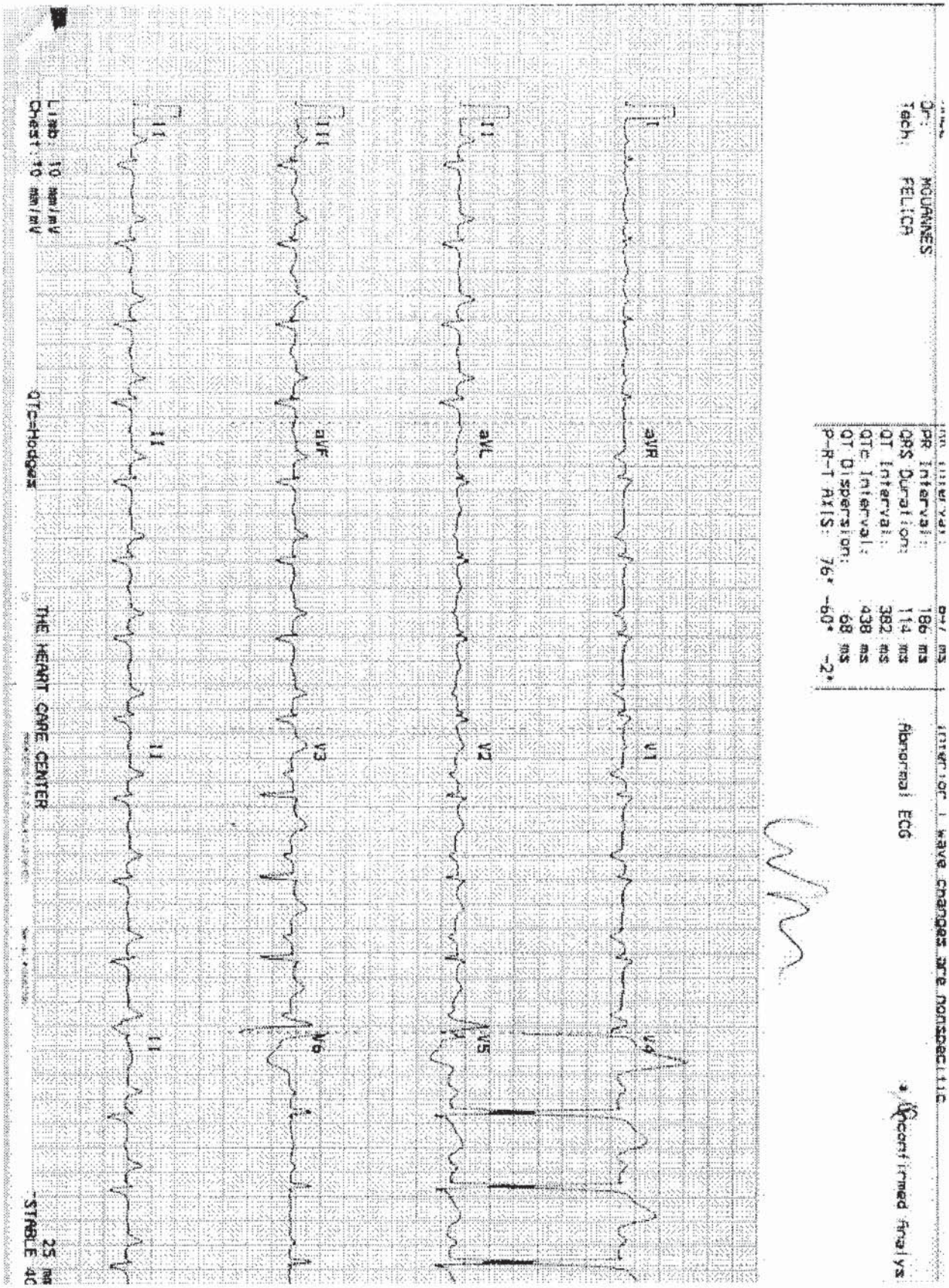
Dr:
Tech: MOJARRES, FELICA
PR Interval: 186 ms
QRS Duration: 114 ms
QT Interval: 382 ms
QTc Interval: 438 ms
QT Dispersion: 68 ms
P-R-T AXIS: 76° -60° -2°
Abnormal ECG
Unconfirmed analys
I wave changes are nonspecific
Lead: 10 mm/mV
Chest: 10 mm/mV
QTc=Hodges
THE HEART CARE CENTER
25 mm
STABLE 4C

694802

South Central Regional Medical Center
P.O. Box 607
Laurel, Mississippi 39441

Patient Name: GRAHAM, ALBERT L
DOB/Age: [redacted] 56 years
FIN: 7813488
MRN: 006199085
Accession No: RA-07303267
Location/Bed: LW 141
Patient Type: OP/Adult

RADIOLOGY REPORT

EXAM	EXAM DATE/TIME	ACCESSION NUMBER	ORDERING MD
DX CHEST PA&LAT	10/21/2007 07:36 EDT	RA-07303267	WASSIM E. MOHANNES, MD

CPT #:
71020

REASON:
(1240) PA LAT CXR DX CHEST PAIN PER WC

REPORT

PA AND LATERAL CHEST @ 07:36 HOURS:
The heart is enlarged. Bibasilar edema shows slight improvement from yesterday. Small bibasilar effusions are noted. The pulmonary vasculature is upper normal.

IMPRESSION:
Improving CHF.

Interpreting Physician: D. Frederick Vail, M.D.
Electronically Signed by: D. Frederick Vail, M.D.
Transcriptionist: MP
Transcribed Date/Time: 10/24/2007 10:47
Signed Date/Time: 10/24/2007 12:04
Technologist: SP
**********FINAL**********

PROTECTED HEALTH INFORMATION

SCANNED

Print Date/Time: 10/24/07 12:26

H#6948038

CONSULTATION

GRAHAM, ALBERT
7818488
Wassim Mouannes, M.D.

DATE OF SERVICE: 11/22/07

DATE OF BIRTH: [redacted]

PRIMARY CARE PHYSICIAN: Dr. Mark Norton
REFERRING PHYSICIAN: Dr. Kimberly Dobbs

INDICATION: Congestive heart failure.

HISTORY OF PRESENT ILLNESS: This is a pleasant 56 year old African-American gentleman with a questionable history of irregular heart beat in the past. He had a negative workup a couple of years ago in Pascagoula, Ms, including a stress test. The patient has no significant medical problems except for tobacco and alcohol abuse. He used to walk 6 miles every day up until three weeks ago when he had cold symptoms with cough, fever, and sputum production. He received antibiotics. He never got better. He did actually get progressively short of breath with dyspnea on exertion and subsequently developed orthopnea and paroxysmal nocturnal dyspnea. He did not have any lower extremity edema and no syncope. He did develop chest pain in the last two to three days. Substernal in nature, steady, not related to any deep inspiration. It felt like something pushing from his stomach up into his chest. The patient presented to the emergency room and was found to be in congestive heart failure. He received two doses of IV Lasix with marked improvement in his symptoms. Initial chest x-ray did show pulmonary edema with pleural effusion. His repeat chest x-ray today showed clearing up of his effusions. He had negative cardiac enzymes. His BNP initially was 2000. The patient currently is feeling much better. He denies a previous history of heart disease except for a little irregular heart beat. Denies any previous history of myocardial infarction, hypertension, diabetes or hypercholesterolemia.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY: Appendectomy.

SOCIAL HISTORY: He smokes about a pack a day. He drinks about 6 beers every day. He denies any heavy liquor.

FAMILY HISTORY: His sister has congestive heart failure and chronic obstructive pulmonary disease. His mother is healthy. His father's history is unknown.

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CONSULTATION

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7818488
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CONTINUED, PAGE 2

ALLERGIES: No known drug allergies.

HOME MEDICATIONS: Multivitamins.

REVIEW OF SYSTEMS:

General:	The patient admits to losing about 5 lbs in the last two to three weeks. Denies any fever or chills at the present time.
HEENT:	No headache, no blurry vision.
Cardiovascular:	As per history of present illness.
Respiratory:	Positive recent cough and upper respiratory tract infection.
GI:	No nausea, vomiting, diarrhea or constipation.
GU:	No hematuria, no dysuria.
Musculoskeletal:	No myalgias, no arthralgias.
Endocrine:	No heat or cold intolerance.
Neurological:	No history of stroke or seizures.
Psychological:	No history of anxiety or depression.

The rest of the review of systems is negative.

PHYSICAL EXAMINATION: Temperature 98.2, pulse 94, blood pressure 112/86.

HEENT:	Pupils are equal, round and reactive to light and accommodation. Extraocular movements are intact.
NECK:	Mild jugular venous distention, no bruits.
CARDIOVASCULAR:	Regular rate and rhythm with a II/VI holosystolic murmur at the apex.
CHEST:	Lungs have mild basilar rales inferiorly on the right side.
ABDOMEN:	Soft, non-tender, non-distended. No shifting dullness appreciated.
EXTREMITIES:	Good peripheral pulses. No clubbing, cyanosis or edema.
NEUROLOGICAL:	Intact.
SKIN:	Warm and dry.

ACCESSORY DATA: His TSH was normal. His creatinine was 1.4, BUN 22, sodium 139, potassium 3.8, chloride 105 and CO2 26. His magnesium level was normal. His AST was normal. His D-dimer was mildly elevated at 327. CT of the chest showed no evidence of pulmonary embolism, moderately large right pleural effusion, congestive heart failure, mediastinal adenopathy, inflammatory vs neoplastic process.

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CONTINUED, PAGE 3

IMPRESSION:

1. Acute congestive heart failure, new onset.
2. Severe left ventricular dysfunction, ejection fraction 15%, probably viral cardiomyopathy vs alcoholic cardiomyopathy. Doubt ischemia in nature.
3. Moderate to severe mitral regurgitation.
4. Alcohol and tobacco abuse.
5. Mild renal insufficiency.
6. Premature ventricular contractions.
7. Atypical chest pain on admission, resolved.

PLAN: At this time we are going to start the patient on Coreg 3.125 mgs po bid. We are going to start him on Lisinopril 2.5 mgs po bid, Lasix 20 mgs po daily, and Aldactone 12.5 mgs po daily. We are going to go ahead and schedule the patient for CT angiogram of the chest to rule out coronary artery disease. We will titrate slowly his ACE inhibitor and Beta blocker as tolerated. I instructed the patient to avoid all kind of alcohol and all kind of tobacco products. He was also to go on a low salt diet as well. Thank you for allowing me to participate in the care of this pleasant patient. I will be happy to follow the patient with you.

Wassim Mouannes, M.D.

dd: 11/22/07
dt: 11/23/07/ne

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